UNIVERSITY STAFF OR ACADEMIC PERSONNEL:

The University of Washington provides reasonable accommodations for employees with sensory, mental or physical disabilities. A reasonable accommodation is an accommodation that enables the employee to perform the essential functions of their position, is medically necessary, and does not create an undue hardship. For detailed information on the accommodation request process, please see the "Disability Accommodation Request Process for Employees and Appointees" on the University Human Resources website at:

http://hr.uw.edu/policies/disability-accommodation/

Please complete this request form and return it to the Disability Services Office. **You are not required to disclose to your immediate supervisor the medical basis for a requested accommodation.** If more information is needed, the University may request that you ask your health care provider to confirm your disability and/or the need for the requested accommodation. **It is your responsibility to see that your health care provider returns the "Health Care Provider Statement" (UoW 1206) to the Disability Services Office.** If more specific information is needed to respond to your request, a Job Analysis for your position may be prepared. A completed copy of the Job Analysis will be shared with you and your health care provider.

If you are **only** requesting an ergonomic workstation evaluation, you do not need to complete this form. Please contact Environmental Health & Safety at 206-543-7262 or visit their website at www.ehs.washington.edu to learn more about ergonomic resources.

Medical records are confidential and are maintained in the Academic or Staff Human Resource offices and/or Disability Services Office, **not** in departmental files.

University Staff: professional, classified non-union and contract-classified staff, nonpermanent hourly and intermittent staff, hourly paid student employees, and all other non-academic employees.

If you have questions regarding accommodation, please contact your Human Resources Consultant or the Disability Services Office. A list of the Human Resource Operations offices is provided below.

HUMAN RESOURCES OPERATIONS OFFICES

CAMPUS HR OPERATIONS		MEDICAL CENTERS HR OPERATIONS		
206-543-2354 (v) 206-685-0636 (fax) BOX 354963	HMC	206-744-9220 (v) 206-744-9955 (fax) BOX 359715	UWMC	206-598-6116 (v) 206-598-4610 (fax) BOX 356054

Academic Personnel: faculty, librarians, fellows, residents, graduate student service appointees or other academic personnel If you have questions regarding accommodation, please contact the Disability Services Office, or one of the resources below:

CONTACTS	
General Information:	Disability Services Office Box 354560 206-543-6450 (v); 206-543-6452 (tty); 206-685-7264 (fax)
Librarians:	Senior Associate Dean of University Libraries Box 352900 206-685-1978 (v); 206-685-8727 (fax)
Residents and Fellows in School of Medicine:	Graduate Medical Education Office Box 358047 206-543-6806 (v)
Faculty, graduate students and all other academic personnel:	Academic Human Resources Box 351270 206-543-5630 (v)

To request this form or other accommodation related materials in an alternate format, or to request an interpreter or other accommodation during the disability accommodation process, please contact the Disability Services Office, 206-543-6450 (voice), 206-543-6452 (tty), or dso@uw.edu.

ACCOMMODATION REQUEST FOR DISABILITY OR SERIOUS MEDICAL CONDITION

EMPLOYEE: To request accommodation, please **print**, **complete** and **sign** this form. **Do not include diagnosis or medical reason**. Please **make a copy** of the form for your records. Return the completed form to the **Disability Services Office, 4300 Roosevelt Way NE, 2nd Floor, Seattle, WA 98195-4560 (USPS) or Box 354560 (campus mail) or FAX: 206-685-7264**.
RECEIVING DEPARTMENT: For questions regarding staff requests, contact your Human Resources Consultant. For questions regarding requests from academic personnel, contact: **Faculty** –appropriate Dean's Office; **Librarians** – Senior Associate Dean of University Libraries; **Residents/Fellows in the School of Medicine** – Graduate Medical Education Office; **All Others** – Disability Service Office.

SECTION I – EMPLOYEE INFORMATION

Last Name:	First Name:	Middle:	Email:	Employee ID Number:

Department:	Box Number:	Job Title:	Phone:	Work Location/Building:

Name of Immediate Supervisor:	Supervisor's Email:	Supervisor's Phone:	Supervisor's Box Number:

SECTION II – REQUEST INFORMATION

Contact the Disability Services Office, dso@uw.edu, Box 354560, 206-543-6450 (v), 206-543-6452 (tty) if you have questions about any of the accommodations listed below.

☐ **Assistive equipment.** Please describe equipment you are requesting that the University provide:

☐ **Facilities modification (e.g., doors widened, ramps installed).** Please describe:

☐ **Interpreter (Sign Language), reader, or real time captioning.**

☐ **Classroom Reassignment.** Please describe (include current and desired assignment):

☐ **Disability Parking or Transportation.**

☐ **Disability parking permit. If you have WA State disability parking tags, indicate tag number** _____ **and expiration date** _____

☐ **Alternate transportation (Dial-A-Ride)**

Duration requested (check one): ☐ Short term (6-8 weeks) ☐ Long term

If change is significant or if you have questions: **staff employees**: contact your Human Resources Consultant. **Academic personnel**: contact the office specified on the cover page.

☐ **Leave of absence or intermittent leave use:** Please complete a copy of departmental leave form.

Duration requested: / / until / /

☐ **Reduction in work schedule:** Please describe:

Duration requested: / / until / /

☐ **Modification of job duties:** Please describe:

Duration requested: / / until / /

☐ **Other change in work schedule.** Please describe:

☐ **Other accommodation.** Please describe:

☐ **If this request is due to an on-the-job injury or illness, please complete the following:**

Date of injury or onset of illness: / /

Have you filed a claim with the Department of Labor & Industries? ☐ Yes ☐ No*

*If no, contact your health care provider to initiate workers' compensation claim.

Please describe how the accommodation(s) requested above will allow you to perform the essential functions of your position (attach separate sheet if necessary):

Employee Signature:_____ Date: _____ Home Phone: _____